

**TRANSMITTAL AND NOTICE OF APPROVAL OF
STATE PLAN MATERIAL**
FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER:

0 4 — 2 0

2. STATE:

New York

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL
SECURITY ACT (MEDICAID)TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE

April 1, 1994

5. TYPE OF PLAN MATERIAL (Check One):

☐ NEW STATE PLAN☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)

6. FEDERAL STATUTE/REGULATION CITATION:

42 CFR Part 447

7. FEDERAL BUDGET IMPACT:

a. FFY 1993-1994 \$ 0

b. FFY 1994-1995 \$ 0

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Attachment 4.19-A Part I Pages 236,237,238,239,
240,241,242,243

*** SEE REMARKS

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION
OR ATTACHMENT (If Applicable): ~~As Previous Pages:~~Attachment 4.19-A Part I Pages 236,237,238,
239,240,241,242,243

10. SUBJECT OF AMENDMENT:

Inpatient Hospital Services - Disproportionate Share Limitations

11. GOVERNOR'S REVIEW (Check One):

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT☐ OTHER, AS SPECIFIED:☒ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:

Michael J. Dowling

14. TITLE:

Commissioner

15. DATE SUBMITTED:

June 30, 1994

16. RETURN TO:

New York State Department of Social Services
40 North Pearl Street
Albany, New York 12243

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17. DATE RECEIVED: JUL 1 - 1994 (PM 6/30/94)

18. DATE APPROVED: JUL 06 2001

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:

04/01/94

21. TYPED NAME:

Sue Kelly

20. SIGNATURE OF REGIONAL OFFICIAL:

22. TITLE: Associate Regional Administrator
Division of Medicaid and State Operation

23. REMARKS:

As per State letter dated 03/30/01 all originally submitted
pages have been replaced as follows: Attachment 4.19-A Part I
pages 239,240, 241, 242, 243, 244, 245, 246, 246a, 246(b), 246(c),
246(d), 246(e), 246(f) Attachment 4.19-A Part II page 9(a), 9(b),
9(c), 9(d), 9(e), 9(f) Attachment 4.19-A Part III page 2(c) and
page 7.

Section 86-1.87 Disproportionate Share Limitations

(a) Effective April 1, 1994, and thereafter for public hospitals and April 1, 1995, and thereafter for all other hospitals, disproportionate share payment distributions made to general hospitals pursuant to sections 86-1.65, 86-1.74, 86-1.84 and 86-1.85 of this Attachment shall be limited in accordance with the provisions of this section. The latest available annual cost report submitted by a hospital prior to the disproportionate share distribution period shall be used to determine eligibility pursuant to subdivisions (b) and (c) of this section and for projected limits pursuant to subdivision (g) of this section. Annual cost reports having an end date in the applicable annual disproportionate share distribution period, or for certain state-operated general hospitals annual cost reports having an end date in the subsequent annual disproportionate share distribution period, shall be used to reconcile limits pursuant to subdivision (h) of this section.

(b) Effective April 1, 1994, general hospitals whose inpatient Medicaid eligible patient days are less than one percent of total inpatient patient days shall not be eligible to receive disproportionate share distributions.

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(c) For the period April 1, 1994, through March 31, 1995,
the disproportionate share limit of public general hospitals with
inpatient Medicaid eligible patient days, as a percentage of
total inpatient patient days, of at least one standard deviation
above the statewide mean Medicaid patient day percentage shall be
increased to 200 percent of the disproportionate share limit
determined pursuant to subdivision (d) of this section. This
increase shall be contingent upon acceptance by the Secretary of
the federal Department of Health and Human Services of the
Governor's certification that the hospital's applicable minimum
amount is used for health services during the year. Payments to
public hospitals in excess of 100 percent of unreimbursed costs
shall not be distributed until the facility submits to the
Commissioner a written certification signed by its Chief
Executive and/or Financial Officer, stating that all
distributions in excess of the 100 percent limit will be used for
health services.

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(d) No general hospital shall receive in total from disproportionate share payment distributions an amount which exceeds the costs incurred during the periods described in subdivision (a) of this section for furnishing inpatient and ambulatory hospital services to individuals who are eligible for Medicaid benefits pursuant to title XIX of the federal Social Security Act (hereinafter referred to as "Medicaid cost") or to individuals who have no health insurance or other source of third party coverage (hereinafter referred to as "self-pay cost"), reduced by medical assistance payments made pursuant to Title XIX of the federal Social Security Act (hereinafter referred to as "Medicaid revenue"), other than disproportionate share payments, and payments by uninsured patients. For purposes of this section, payments to a general hospital for services provided to indigent patients made by the State or a unit of local government within the State shall not be considered a source of third party payment.

(e) For purposes of calculating disproportionate share (DSH) distributions pursuant to paragraphs (a) through (d) hereof, if

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the hospital receiving the distribution is a public hospital
(operated by the State, a city, county or other municipal
subdivision), then the payments determined hereunder are further
limited. Unless the hospital qualifies as a "high DSH" facility
(as defined below), payments made during a distribution period
shall not exceed the cost incurred by the hospital for
furnishing hospital services to Medicaid recipients less non-DSH
reimbursement and to uninsured patients less patient payments.
In the case of a hospital defined as "high-DSH", payments made
during a distribution period shall not exceed 200 percent of the
amount described in the previous sentence. To be considered a
"high-DSH" facility, a hospital must have a Medicaid inpatient
utilization rate of at least one standard deviation above the
mean Medicaid inpatient utilization rate for hospitals receiving
Medicaid payments in the State, or have the largest number of
Medicaid inpatient days of any hospital in the State in the
previous distribution period. Previous years' data for both
uninsured and Medicaid cost and payments shall be used to

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estimate the limitation. A cost determination of both the uninsured and the Medicaid inpatient costs shall be made upon receipt of an appropriate report.

(f) In order to ensure the continued flow of disproportionate share payments to hospitals, the Commissioner shall make projections of each hospital's disproportionate share limitation based on the most current data available from the hospital's annual cost and bad debt and charity care reports. The Commissioner may use certified reports submitted pursuant to subdivision (h) of this section, rather than annual cost reports for the same fiscal period, to estimate Medicaid and self-pay costs in the projection methodology for a particular rate year. This shall be referred to as the "projection methodology."
Subsequent to the receipt of a hospital's annual costs report having an end date in the applicable annual disproportionate share distribution period, or for certain state-operated general hospitals whose annual cost reports have an end date within the subsequent annual period, each hospital's disproportionate share limitation shall be reconciled to the actual rate year data. This shall be referred to as the "reconciliation methodology."

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(g) Projection methodology. Each hospital's projected disproportionate share limitation for each rate year shall be calculated using base year data and statistics for the base year two years immediately preceding the rate year and shall be calculated as follows:

(1) Medicaid revenue per unit of inpatient service shall be determined by using the Medicaid rates effective January 1st, for such rate year, after hotline changes for both case payment and exempt units, including prospective adjustments for prior rate years, excluding prospective adjustments for those rate years prior to the implementation of the disproportionate share payment limits.

(i) For general hospitals, except financially distressed hospitals, the Medicaid revenue per unit of inpatient service shall be reduced by 1.7 percent to provide for consideration of assessments paid by hospitals pursuant to state law.

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(ii) For all hospitals, revenues for the health maintenance organization/prepaid health services plan inpatient services for Medicaid patients shall be reduced by 15 percent.

(2) Medicaid cost per unit of inpatient service shall be determined as follows:

(i) Base year non-Medicare inpatient costs for such rate year, for each service area costs center, shall be divided by units of service, and, except for exempt hospitals and exempt units of general hospitals, adjusted by the non-Medicare case mix index to arrive at the non-Medicare inpatient case mix neutral cost per unit.

(ii) The result, except for exempt hospitals and exempt units of general hospitals, shall be multiplied by the Medicaid case mix index, and then increased in each year from the base year to the rate year by two percent for anticipated changes in projected Medicaid and self-pay losses resulting from Medicaid and self-pay case mix and volume increases. Such amount shall then be trended to the rate year pursuant to section 86-1.58 of this Attachment.

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(3) Medicaid inpatient gain/(loss) shall be equal to such hospital's Medicaid revenue per unit of inpatient service reduced by Medicaid cost per unit of inpatient service, for each service area cost center, multiplied by Medicaid units for each such cost center and summed for all such inpatient costs centers.

(4) Medicaid revenue per unit of outpatient service for each outpatient service category shall be determined by using the latest available Medicaid rate per visit for each outpatient service category. The calculated cost-based clinic and ambulatory surgery average rates per visit, as provided to hospitals by the Commissioner, shall be used instead of Products of Ambulatory Care and Products of Ambulatory Care Surgery rates.

(i) For general hospitals, except financially distressed hospitals, the Medicaid revenue per unit of outpatient service shall be reduced by .7 percent to provide for consideration of assessments paid by hospitals pursuant to state law.

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(5) Medicaid cost per unit of outpatient service for each outpatient area shall be determined by dividing the applicable base year outpatient costs, for the service area cost center, by the latest available reported total outpatient visits for such cost centers. The result for each such cost center shall then be increased in each year from the base year to the rate year by two percent for anticipated changes in projected Medicaid and self-pay losses resulting from Medicaid and self-pay case mix and volume increases. Such amount shall then be trended to the rate year pursuant to section 86-1.58 of this Attachment.

(6) Medicaid outpatient gain/(loss) shall be equal to the hospital's Medicaid revenue per unit of outpatient service reduced by Medicaid cost per unit of outpatient service, for each service area cost center, multiplied by Medicaid units for each such cost center and summed for all such costs centers.

(7) Self-pay cost per unit of inpatient service for each rate year shall be calculated for case mix payment cases by multiplying the non-Medicare case mix neutral cost per unit as defined in

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subparagraph (i) of paragraph (2) of subdivision (g) of this section by the hospital's self-pay case mix index. For self-pay exempt unit cases, self-pay cost per unit for each rate year shall be determined by dividing non-Medicare base year costs for such exempt units by base year exempt unit days. The results of these calculations shall then be increased in each year from the base year to the rate year by two percent for anticipated changes in projected Medicaid and self-pay losses resulting from Medicaid and self-pay case mix and volume increases. Such amount shall then be trended to the rate year pursuant to section 86-1.58 of this Attachment.

(8) Self-pay inpatient costs for case payment and exempt unit cases shall be determined by multiplying the self-pay cost per unit of inpatient service by the most currently available reported number of units.

(9) Self-pay inpatient (loss) shall be determined by multiplying inpatient self-pay costs for case payment and exempt

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unit cases by the most current uncollectible percentage for case payment and exempt unit cases reported by each hospital to the Commissioner on its bad debt and charity care reports.

(10) Self-pay gross cost per visit for each outpatient service area cost center shall be estimated, using as a proxy the Medicaid cost per unit of outpatient service as defined in paragraph (5) of this subdivision.

(11) Self-pay outpatient gross cost for each outpatient service area cost center shall be calculated by multiplying the latest available reported self-pay outpatient visits for each cost center by self-pay gross cost per visit for each cost center.

(12) Self-pay outpatient (loss) shall be determined by multiplying self-pay outpatient gross cost for each outpatient service area cost center by the most current uncollectible percentage for each cost center reported by the hospital to the Commissioner on its bad debt and charity care reports and summing the results for all outpatient service area cost centers.

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(13) Each hospital's disproportionate share limit shall be equal to the sum of its inpatient and outpatient gains/(losses) for both Medicaid and self-pay as determined in accordance with this subdivision.

(h) Reconciliation methodology. The Commissioner shall revise the projected limitation based on actual data reported to the Commissioner for such rate year in accordance with the following and in accordance with final regulations issued by the federal Department of Health and Human Services implementing 42 U.S.C. 1396-r. The Commissioner shall revise the projected limitations for each hospital within eight months from the date required reports are submitted to the Department, except if such reports are determined to be unacceptable by the Department. For hospitals which have submitted unacceptable reports, the Commissioner shall revise the projected limitations within eight months from the date acceptable reports have been resubmitted to the Department. The Department shall commence implementation of revised limitations in the quarter immediately following the quarter during which this SPA is approved by HCFA.

(1) Each hospital shall submit by the same date the annual cost reports which are required to be filed pursuant to section 86-1.3 of this Attachment and a disproportionate share limitation

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schedule in a form and manner prescribed by the Commissioner
within which the hospital shall calculate, in accordance with the
instructions, its inpatient and outpatient Medicaid and self-pay
gains/(losses) during the cost reporting year. The
disproportionate share limitation schedule shall be accompanied
by a certification by the hospital's independent public
accountant which provides the Commissioner sufficient assurance
as to the accuracy of the information contained in such schedule.
The final limit shall be calculated by excluding inpatient and
outpatient Medicaid revenue impacts resulting from prospective
adjustments for periods prior to the implementation of the
disproportionate share payment limits from the inpatient and
outpatient Medicaid and self-pay gains/(losses) reported on the
disproportionate share limitation schedule.

(2) The limitations established pursuant to this subdivision
shall represent the final limits applicable to disproportionate
share general hospital distributions described in subdivision (k)
of section 86-1.65 of this Attachment for each applicable annual
rate year.

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Supersedes TN New Effective Date APR 01 1994

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(3) Failure of a hospital to submit the information required by this section in a form acceptable to the Commissioner shall result in the immediate withholding of all subsequent disproportionate share distributions. Such withholding shall continue until the hospital complies with the reporting requirements of this subdivision.

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by total patient discharges expressed as a percentage. The percentages shall be calculated based upon 1989 data developed by the Office of Mental Health.

The scale utilized for development of a supplementary low income patient adjustment for a public psychiatric hospital shall be as follows:

Low Income Patient Percentages	Supplemental Percentage Coverage of Need
35+ to 55%	20%
55+ to 60%	25%
60+ to 65%	30%
65+ to 70%	37.5%
70+%	45%

[The supplemental percentage coverage of need shall not be allocated between case based and exempt units and the low income patient percentage for public psychiatric hospitals shall be calculated based on 1989 data developed by the Office of Mental Health.] The adjustment for public psychiatric hospitals shall be limited such that this amount when added to the disproportionate share adjustment described above shall not exceed 90% of need.

X. DISPROPORTIONATE SHARE LIMITATIONS

Effective April 1, 1994, and thereafter, for OMH facilities, disproportionate share payment distributions made pursuant to

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this Part of this Attachment shall be limited in accordance with the provisions of this section.

Effective April 1, 1994, OMH facilities whose inpatient Medicaid eligible patient days are less than one percent of total inpatient patient days shall not be eligible to receive disproportionate share distributions.

Effective for the state fiscal year beginning April 1, 1994, disproportionate share payments to OHM facilities with inpatient Medicaid eligible patient days, as a percentage of total inpatient patient days, of at least one standard deviation above the statewide mean Medicaid patient day percentage shall be increased to 200 percent of the disproportionate share limit determined in accordance with this section. This increase shall be contingent upon acceptance by the Secretary of the federal Department of Health and Human Services of the Governor's certification that the hospital's applicable minimum amount is used for health services during the year. Federal funds associated with payments to OMH facilities in excess of 100 percent of unreimbursed costs shall not be distributed unless OMH submits to the Commissioner a written certification stating

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city, county or other municipal subdivision), then the payments determined hereunder are further limited. Unless the hospital qualifies as a "high DSH" facility (as defined below), payments made during a distribution period shall not exceed the cost incurred by the hospital for furnishing hospital services to Medicaid recipients less non-DSH reimbursement and to uninsured patients less patient payments. In the case of a hospital defined as "high-DSH", payments made during a distribution period shall equal 200 percent of the amount described in the previous sentence. To be considered at "high-DSH" facility, a hospital must have a Medicaid inpatient utilization rate of at least one standard deviation above the mean Medicaid inpatient utilization rate for hospitals receiving Medicaid payments in the State, or have the largest number of Medicaid inpatient days of any hospital in the State in the previous distribution period. Previous years' data for both uninsured and Medicaid cost and payments shall be used to estimate the limitation. A cost determination of both the uninsured and the Medicaid inpatient costs shall be made upon receipt of an appropriate report.

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that all distributions in excess of the 100 percent limit will be used for health services.

No OMH facility shall receive in total from disproportionate share payment distributions an amount which exceeds the costs incurred for furnishing inpatient and ambulatory hospital services to individuals who are eligible for Medicaid benefits pursuant to title XIX of the federal Social Security Act or to individuals who have no health insurance or other source of third party coverage, reduced by medical assistance payments made pursuant to Title XIX of the federal Social Security Act , other than disproportionate share payments, and payments by uninsured patients. For purposes of this section, payments to OMH facilities for services provided to indigent patients made by the State or a unit of local government within the State shall not be considered a source of third party payment.

For purposes of calculating disproportionate share (DSH) distributions pursuant to this section, if the hospital receiving the distribution is a public hospital (operated by the State, a

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city, county or other municipal subdivision), then the payments determined hereunder are further limited. Unless the hospital qualifies as a "high DSH" facility (as defined below), payments made during a distribution period shall not exceed the cost incurred by the hospital for furnishing hospital services to Medicaid recipients less non-DSH reimbursement and to uninsured patients less patient payments. In the case of a hospital defined as "high-DSH", payments made during a distribution period shall equal 200 percent of the amount described in the previous sentence. To be considered at "high-DSH" facility, a hospital must have a Medicaid inpatient utilization rate of at least one standard deviation above the mean Medicaid inpatient utilization rate for hospitals receiving Medicaid payments in the State, or have the largest number of Medicaid inpatient days of any hospital in the State in the previous distribution period. Previous years' data for both uninsured and Medicaid cost and payments shall be used to estimate the limitation. A cost determination of both the uninsured and the Medicaid inpatient costs shall be made upon receipt of an appropriate report.

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Facility specific limitations will be estimated before the beginning of each fiscal year. The estimate will be based on the most recently available actual cost and revenue information as adjusted for expected changes in cost and revenue. These estimated facility-specific limitations will be recalculated to reflect actual information after the year has been completed and the necessary information has been compiled. Once the actual limitations for the year are known, adjustments will be made as necessary to the disproportionate share amounts paid to the facility. If it is determined that disproportionate share payments to a particular facility exceed the facility-specific calculation, a recoupment will be made. Alternatively, if it is determined that additional disproportionate share payment are due the facility, such additional payments will be made.

XI. TRANSFER OF OWNERSHIP

In establishing an appropriate allowance for depreciation and for interest on capital indebtedness and (if applicable) a return on equity capital with respect to an asset of a hospital which has undergone a change of ownership, the valuation of the

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asset after such change in ownership shall be the lesser of the allowable acquisition cost of such asset to the owner of record as of July 18, 1984 (or, in the case of an asset not in existence as of such date, the first owner of record of the asset after such date), or the acquisition cost of such asset to the new owner.

TN 94-26 Approval Date JUN 06 2001
Supersedes TN New Effective Date APR 01 1994

A "disproportionate share hospital" for purposes of receiving additional disproportionate share payments under this provision is any hospital which furnishes medical or remedial care to a qualified low-income person without expectation of payment from the person due to the patient's inability to pay as documented by his or her having met the income and resource standards for Home Relief benefits as set forth above. In addition, a "disproportionate share hospital" (except hospitals serving an in-patient population predominantly comprised of persons under 18 years of age and hospitals which did not offer non-emergency obstetrical care on or before December 21, 1987) must have at least two obstetricians with staff privileges who have agreed to provide obstetrical care and services to Medicaid-eligible patients on a non-emergency basis.

The amount of this disproportionate share adjustment will vary by hospital and reflect the dollar amount of payments from the State to the hospital for services provided to low income patients. For each hospital such adjustments shall be paid in the normal Medicaid payment process and according to established rates or fees. To receive payment of this adjustment each hospital must submit a claim in the form and manner specified by this Department.

For purposes of calculating disproportionate share (DSH) distributions pursuant to this section, if the hospital receiving the distribution is a public hospital (operated by the State, a city, county or other municipal subdivision), then the payments determined hereunder are further limited. Unless the hospital qualifies as a "high DSH" facility (as defined below), payments made during a distribution period shall not exceed the cost incurred by the hospital for furnishing hospital services to Medicaid recipients less non-DSH reimbursement and to uninsured patients less patient payments. In the case of a hospital defined as "high-DSH", payments made during a distribution period shall be limited to 200 percent of the amount described in the previous sentence. To be considered a "high-DSH" facility, a hospital must have a Medicaid inpatient utilization rate of at least one standard deviation above the mean Medicaid inpatient utilization rate for hospitals receiving Medicaid payments in the State, or have the largest number of Medicaid inpatient days of any hospital in the State in the previous distribution period. Previous years' data for both uninsured and Medicaid cost and payments shall be used to estimate the limitation. A cost determination of both the uninsured and the Medicaid inpatient costs shall be made upon receipt of an appropriate report.

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Supersedes TN 91-58 Effective Date APR 02 1991

A "disproportionate share hospital" for purposes of receiving additional disproportionate share payments under this provision is any hospital which furnishes medical or remedial care to a qualified low-income person without expectation of payment from the person due to the patient's inability to pay as documented by his or her having met the income and resource standards for Home Relief benefits as set forth above. In addition, a "disproportionate share hospital" (except hospitals serving an in-patient population predominantly comprised of persons under 18 years of age and hospitals which did not offer non-emergency obstetrical care on or before December 21, 1987) must have at least two obstetricians with staff privileges who have agreed to provide obstetrical care and services to Medicaid-eligible patients on a non-emergency basis.

The amount of this disproportionate share adjustment will vary by hospital and reflect the dollar amount of payments from the State to the hospital for services provided to low income patients. For each hospital such adjustments shall be paid in the normal Medicaid payment process and according to established rates or fees. To receive payment of this adjustment each hospital must submit a claim in the form and manner specified by this Department.

For purposes of calculating disproportionate share (DSH) distributions pursuant to this section, if the hospital receiving the distribution is a public hospital (operated by the State, a city, county or other municipal subdivision), then the payments determined hereunder are further limited. Unless the hospital qualifies as a "high DSH" facility (as defined below), payments made during a distribution period shall not exceed the cost incurred by the hospital for furnishing hospital services to Medicaid recipients less non-DSH reimbursement and to uninsured patients less patient payments. In the case of a hospital defined as "high-DSH", payments made during a distribution period shall be limited to 200 percent of the amount described in the previous sentence. To be considered a "high-DSH" facility, a hospital must have a Medicaid inpatient utilization rate of at least one standard deviation above the mean Medicaid inpatient utilization rate for hospitals receiving Medicaid payments in the State, or have the largest number of Medicaid inpatient days of any hospital in the State in the previous distribution period. Previous years' data for both uninsured and Medicaid cost and payments shall be used to estimate the limitation. A cost determination of both the uninsured and the Medicaid inpatient costs shall be made upon receipt of an appropriate report.

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